Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Request to Change Reimbursement

Pharmacy Rates Section
Fax: (360) 725-1982
http://maa.dshs.wa.gov/pharmacy/
Phone: 1-800-848-2842, Monday through Friday, 9:00am-12:00pm and 1:00pm-4:45pm
*******Please note: You must transmit a claim prior to faxing this form.*******

Authorization Type
- ☐ Update to existing waive authorization #_____
- ☐ New waive request

Pricing conflicts**
- ☐ Reimbursement less than cost
  - What is your actual unit cost?_____
  - What is your AWP unit cost?_____
  - Who is your wholesaler?_____
- ☐ Availability issue
  - When will product be available?_____
  - Who is your wholesaler?_____

****NOTE: This form is NOT for dispense as written (DAW) requests for brand name. Please continue to submit those requests via fax to (360) 725-2141.**

Patient Information

Name_____
PIC
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Nursing home patient? Y ☐ N☐ Unknown ☐

Pharmacy Information
Pharmacy Name_____
NABP_____
Fax _____
Phone _____

Prescriber Information
DEA #_____

Drug Information
Drug name_____
Rx#_____
NDC_____
Directions for use (sig)_____
Quantity_____
Date(s) of fill_____
Days supply_____

FOR DSHS/MAA STAFF USE ONLY
- ❑ *Form not complete or illegible. Unable to process request. Please complete and refax.*
- ❑ *Unable to verify cost – please submit invoice.*
- ❑ *Authorized. Use #_____*
- ❑ *Request received. Verifying cost information.*
- ❑ *Pricing on this NDC has been corrected – please reverse and re-run claim.*
- ❑ *Denied*
- ❑ *Other _____*

Name of contact person @ pharmacy_____

PRS Staff _____
Date_____